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ABSTRACT

One component of psychotherapy is the type of psychotherapeutic atmosphere created by the therapist. The various character structures of patients require different psychotherapeutic atmospheres. Three character structures are identifiable, each distinguished by a style of social cognition which parallels a stage of cognition in the child as described by Piaget. The social cognition of the symbolic adult who confuses identity and reality parallels the symbolic-stage of a child's cognition. An empathetic-immersion atmosphere in which the patient feels connected to the therapist and the therapist manages the connection is generally most effective with this type of patient. The intuitive adult who has a heteronomous superego and judges on the basis of appearance corresponds to the intuitive-stage child and tends to benefit from a parenting psychotherapeutic atmosphere. The operational adult who has an autonomous superego and judges on the basis of abiding values parallels the concrete operational-stage child. This type of patient is most likely to benefit from an almost pure scientific laboratory atmosphere which relies on transference interpretation as its major tool. This Piagetian-based model of character structure can help therapists to distinguish different types of patients and to understand the experiences and effects of different psychotherapy approaches. (NRB)

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AN ASPECT OF PSYCHOTHERAPY UTILIZING A PIAGETIAN MODEL OF CHARACTER STRUCTURE*

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A comprehensive psychotherapy approach should include at least three aspects: Purpose or goal of the therapy, techniques to be used in pursuit of the goal, and type of psychotherapeutic setting or atmosphere to be created. The focus of this paper is primarily on the psychotherapeutic atmosphere. We suggest that different character structures of patients call for the creation of different psychotherapeutic atmospheres or contexts, that no single context is appropriate for all patients.

Previously we described three types of adult character structure.[1,2] We offered a Piagetian framework as the theoretical base for understanding the development and organization of character structure. Here we will discuss how that organization of character structure impacts treatment.

Two clinical vignettes will illustrate the importance of the therapist's providing a psychotherapeutic context that is appropriate for a given character structure. Psychotherapeutic context is defined here as the atmosphere, situation, frame or setting of therapy created by the therapist. It consists of the abiding stance taken by the therapist and the message conveyed in taking that particular stance. While distinct from the specific techniques -- e.g. interpretation, suggestion, manipulation -- a particular psychotherapeutic context usually calls for a particular technique or set of techniques and not for others. For example, the classical psychoanalytic context relies on interpretation and avoids suggestion and manipulation.

CLINICAL MATERIAL

Ms. B and Mr. A's therapists created similar psychotherapeutic contexts or atmospheres. The two patients made similar assumptions about their therapists. Each of the therapists drew attention to his patient's assumption.

However, the two patients responded to the therapists' similar interventions differently.

Case 1

Ms. B, a 26-year-old, single, unemployed clerical worker, sought treatment because of difficulty in choosing a career. She had recently been dismissed from two positions. She realized that in the first position she had tried to do things the way she thought they should be done when she should have been doing what she was told. The second dismissal, however, surprised her since it was a "girl Friday" job where she thought functioning autonomously would be valued.

Certain careers were not open to Ms. B because she did not have a college degree. She had quit three units short of graduation, having decided a degree was not necessary. She then left her home in the East to "go out on my own," but still had frequent communication with her parents, who telephoned every week and who tried to help by suggesting career possibilities and supporting any she thought of. Ms. B found herself unable to move ahead on either their suggestions or her own ideas. She brought up many of her ideas about possible careers in therapy and the therapist listened neutrally without giving an opinion on any of them.

One day Ms. B spoke of an interest in accounting. The following week she received a brochure in the mail about an accountant training program.

At the next session, assuming the therapist had responded to her interest by sending the brochure, she thanked him. The therapist, who had been careful to take a neutral stance, asked her why she thought he might have sent the brochure. She then recounted past and present examples of her parents' continual involvement with and investment in her activities. She felt her activities belonged to her parents, mother designing and making her costumes for school plays and attending rehearsals, father accompanying her on her riding lessons and reviewing her progress.

Ms. B had transferred to the therapist the overprotective and controlling qualities of her parents. She realized that a major stumbling block to her choosing a career was that in an attempt to have something of her own she tried to find something that her parents would not approve of. As the weeks went by she discovered that she expected that those in authority roles would have her best interests at heart just as her parents had. She expected her bosses to have taken her good intentions into account and to have allowed her to function in the ways that worked best for her.

Case 2

Mr. A, a 32-year-old, single man, complained of an overriding sense of frustration and anger over the loss of his girlfriend to whom he had been attached for the past five years. His girlfriend left because of his increasing possessiveness and restrictiveness. His father, whom he described

and cold and unloving, had died two years previously and although he expressed no feeling of loss, he began to hold on even more tightly to his girlfriend.

Denying loss by devaluing the lost person was characteristic of Mr. A. When he was eight he was hospitalized many months for rheumatic fever and was then sent to his grandmother's home in the country to recuperate. His mother, who died when he was 10, he described as cold, unloving, frustrating, powerful, and controlling. After the death of his mother he returned to his grandmother, whom he remembers as warm, loving, and admiring. He spoke of sitting by the fireplace conscious of his grandmother's comforting presence in the room.

In treatment Mr. A focused on his father's and mother's worthlessness and his girlfriend's badness. The therapist listened in silence, a silence with which Mr. A seemed to feel quite comfortable. One day, upon entering the therapist's office, Mr. A thanked the therapist for positioning the ashtray in the exact location where he always put it himself. The therapist, who had always maintained a neutral stance, questioned Mr. A about his assumption regarding the placement of the ashtray. The therapist hoped to give him insight into his assumption that the therapist was taking care of him. Mr. A apologized for his mistake, began to talk about plans to move out of the city and about his interest in other modes of therapy. At the end of the session he told the therapist he was cruel to call him on a "social blunder." Despite this interaction, the therapist

continued to pursue an analytic stance, interpreting Mr. A's responses. Mr. A soon discontinued treatment.

The Two Patients Respond Differently to the Same Context

In both of these cases the therapist utilized a passive, opaque-mirror context and in both cases the patient perceived the therapist as a caregiver. In both cases the therapist made an opening move toward a transference interpretation, directed toward making the unconscious conscious. There the similarity ended. Ms. B used the interpretive intervention as information, relating her expectations of the therapist to her remembered early experience with her significant caregivers. As therapy progressed she realized that her expectations of persons in authority positions reflected her early experience with parents who were overprotective and controlling, but also devoted to her best interests. The therapist's intervention had had the effect Freud wrote of: "The transference is overcome by showing the patient that his feelings do not originate in the current situation, and do not really concern the person of the physician, but that he is reproducing something that had happened to him long ago. In this way we require him to transform his repetition into recollection."[8]

Mr. A, on the other hand, took the interpretation as a reprimand and became disengaged from the therapist whom he eventually put into the category of worthless parents and bad girlfriend. Before the interpretation he experienced the therapist's silence as a warm, loving, admiring presence. He

felt a union with the therapist as he had with his grandmother and with his girlfriend before she left him. The intervention disrupted his sense of connectedness with the therapist whom he then experienced as cold and uncaring. He felt the therapist did not understand him or like him.

TREATMENT THEORIES BASED ON DIFFERENT TYPES OF PATIENTS

All of us who practice psychotherapy have had the experience that a given psychotherapeutic context, in this case a neutral or abstinent one, may be effective with one patient or type of patient and ineffective with another patient or type of patient. We have also experienced that a particular technique, in this case a transference interpretation, may be effective with one patient or type of patient or at a particular stage of treatment and ineffective with another patient or type of patient or at other stages of treatment.

Major theories of therapy have grown out of a therapist's experience with a type of patient where one approach is consistently more effective than another. Sullivan[4] developed his interpersonal theory from his work with schizophrenic patients. Kohut[5] developed his empathic immersion approach in his work with narcissistic patients. Earlier Ferenczi[6] advocated an active approach to certain types of patients. He asserted that anxiety hysterics, for example, "in spite of a deep insight into their unconscious complexes, could not get beyond 'dead points' in the analysis until they were compelled to venture out from the retreat of their phobia, and to expose

themselves experimentally to the situation they had avoided."

In a treatment approach as well defined as psychoanalysis is, conflict exists regarding the essence of the treatment and for what type of patient it is effective. Freud[7] considered psychoanalysis to be ineffective with narcissistic individuals because they did not form a transference. Since he viewed transference analysis as essential in psychoanalysis, patients who did not form a transference could not be analyzed. In more recent times Kohut[5] contended that psychoanalysis is an effective mode of treatment for narcissistic individuals when they are approached empathically; that is, when the analyst, relying on merger and identification with the patient's experiences, becomes an "observer from within as well as an observer in the laboratory."[8] He believed these patients do form a transference, not a classical Oedipal one, reflecting love or competitiveness in the areas of sexuality or authority, but instead a mirroring mother or idealized father transference. Freud and Kohut differ on what constitutes a successful outcome of psychoanalysis. Freud[9] saw psychoanalysis as successful, not when the patient was rid of his "morbid reactions" but when, through understanding his unconscious conflicts, he acquired "<u>freedom</u> to choose one way or the other." Kohut[5] held that the healing of the defect in the self, not the understanding of unconscious conflicts, is the essence of successful outcome.

PSYCHOTHERAPUETIC CONTEXT

In support of his experience with narcissistic patients Kohut[5] essentially redefined psychoanalysis. He substituted an empathic immersion for a

a scientific or abstinent context and offered a different purpose or goal. Other psychoanalysts have not gone as far as Kohut. Nevertheless, an ongoing dialogue has developed involving the psychotherapuetic "frame," i.e. the context, whether it should be flexible enough to permit treatment of patients who might not be able to tolerate the pure atmosphere which Freud[10,11] recommended. Freud believed that a pure atmosphere, reflected in the therapist's abstinence (not gratifying the patient's infantile wishes) and anonymity (not revealing information about oneself) was necessary in order for the patient's transference communications to unfold solely out of his inner needs. Greenacre,[12] believing anonymity to be imperative, viewed the emergence of the psychoanalyst into any aspect of the patient's real life as contaminating the transference. She even urged analysts not to participate in social causes which might bring them to public attention. Stone[13] on the other hand, asserted that rules such as abstinence and anonymity were not absolutes. The analyst should use his clinical judgment. He should not be unnecessarily frustrating since the analytic situation itself is a source of suffering. Further, a psychoanalyst's answering questions about himself may sometimes be helpful in the analysis. Stone wrote that the analyst may on occasion even recommend that a patient have a physical examination or seek contraceptive advice. Greenson[14] went further. He wrote that the realistic or genuine relationship between analyst and patient is as important to the analysis as the transference relationship. He recommended a context in which the analyst conveys his concern for the pain the analytic situation brings to the patient as much as for the pain of the illness which the patient brings. While

Brenner[15] agreed with Stone that "the technical rules are not commandments," to be kept under all conditions, he disagreed that the psychoanalytic context is, in and of itself, a source of pain which the analyst should be trying to minimize. Brenner contended that it is the patient's illness, not the psychoanalytic situation itself, that accounts for the patient's experience of it as painful. Langs[16] went further than Brenner. He insisted that the ground rules which form the frame, i.e. the psychotherapeutic context, should not be broken, that a sound frame is essential for the development of a transference neurosis. Relaxing the boundaries of the psychotherapuetic context reflects the analyst's inability to bear the anxiety of frustrating the patient. Abstinence and anonymity must be maintained in order to create a psychotherapeutic situation in which the patient's neurotic needs and wishes are not gratified but are converted into verbalizations and other behavior that may be analyzed.

Our position is close to the position of Freud and Brenner, who recommend the pure psychoanalytic context while allowing that psychoanalysis is not for everyone. While not in total disagreement, we are less close to positions taken by Kohut, Stone and Greenson, who broaden the classic context of psychoanalysis, trying to accommodate a wider range of patients.

We see treatment as falling into three fairly distinct approaches, believing that different treatment atmospheres or contexts need to be created for different types of patients. A near pure scientific laboratory atmosphere, relying on transference interpretation as its major tool, is appropriate for

patients who have a separate identity and an autonomous superego. An empathic immersion atmosphere in which the patient feels connected to the therapist and in which the therapist manages the connection is most effective with those who have not constructed a separate identity. A parenting atmosphere is most helpful to those who, although they have a differentiated identity, do not have an internalized system of values (an autonomous superego), hence depend on the surround to differentiate what is good or bad for them.

The treatment approach, the context or atmosphere of the therapeutic situation and to an extent the techniques utilized, should depend on how the particular patient will process that approach. We believe that patients process treatment, as they do everything else, in terms of their character structure.

THE THREE CHARACTER STRUCTURES

In our earlier work we[1,2] proposed a model of adult character structure consisting of three basic types. Each character type was distinguished by his style of social cognition, that is, his characteristic manner of processing social and emotional data, by his primary social investment, and by the nature of his early experience with significant caregivers.

The style of social cognition for each character type parallels a stage of cognition of the child described by Piaget.[17] The symbolic-stage child's (age 2-4)* cognition parallels the social cognition of the character type we

*All ages are approximate

called symbolic. The symbolic-stage child fails to clearly differentiate self, object, and symbol, to grasp the essence of an object, including the self. The adult who confuses identity and reality, the symbolic character, sees others as extensions of self and uses other persons or objects or events to define himself and to negate his feelings of emptiness or confusion.

The intuitive-stage child's (age 5-7) congnition parallels the social cognition of the character type we called intuitive. The intuitive-stage child judged on the basis of appearance, taking into account only one variable, for example, thinking that high in the glass or full to the brim equals more.[18] The adult with a heteronomous superego, the intuitive character, judges on the basis of appearance, "if it looks good it must be good." He depends on clues external to himself, such as someone else's judgment or an event, to know what is good and bad, including the goodness and badness of himself and others, "if you get caught you are bad."

The concrete operational-stage child's (age 7-11) cognition parallels the social cognition of the character type we called operational. The concrete operational child no longer judges on the basis of appearance, taking into account one variable. He knows when juice is poured from a wide glass into a narrow one that, although it rises higher or to the brim, the amount remains the same.[18] Similarly, an adult with an autonomous superego, the operational character, judges on the basis of abiding values, not influenced primarily by his current affect state or current social situation.

Patients of a given character structure tend to have a common early experience with significant caregivers. An operational character usually experienced his caregivers as having his best interests at heart while sometimes he experienced them as overprotective and controlling. An intuitive character experienced his caregivers as suiting their own convenience or as unavailable or at least as not being very invested in his best interests. A symbolic character experienced having to meet the emotional needs of his caregivers before they would meet his.

Although personality traits continue to develop during the formal operational period (age 12-16), we postulated that during the concrete operational period a child's character structure is set, reconciling how he experienced his caregivers, his social world. We proposed that during the concrete operational period a child is able to coordinate surface discrepant variables such as being encouraged by his caregivers while he takes time to dress himself and being scolded by them when he is slow in a risky situation, such as crossing the street. In his belief that his social world, his caregivers, are invested in his best interests he reconciles apparent discrepancies, being praised when slow in one situation and being reprimanded when slow in another. We see this construct of his social world as comparable to a concrete-operational child's being able to coordinate surface discrepant variables in his understanding of physical values such as quantity.

A child, who experienced caregivers who suited their own convenience,

rather than looking out for his best interests, has not had to coordinate surface discrepant variables. He received a consistent message that his caregivers were concerned with their own interests. If they scolded him it was because they were being inconvenienced. If they praised him, he was doing something they enjoyed. If they offered him something now he could count on it. If they promised something in the future he could not. He learned that tolerating present pain did not guarantee future reward. Since he did not have to deal with weighting future reward against current gratification, he did not have to construct values against which to weigh different options. He dealt with only one option, that which was in front of him at the moment. His value judgments are analogous to the intuitive-stage child's inability to conserve in the physical sphere, who thinks he has more juice if it is poured into a narrow glass,[18] who judges by current appearance.

A child, who learned that he must make his caregivers feel whole and worthwhile in order to enable them to look out for his interests, would have had to ignore certain aspects of himself. For example, a child, who had to appear to be in control in order to reassure his caregivers, would have had to ignore his own fears or his wishes and thus not ever know these parts of himself. Having to become responsive so early to the needs of others he may become a kind of complementary or symbiotic person, a part-person. He experienced wholeness only in his connectedness to another person or to a role. Thus he is dependent on attachment to define his identity. He is like Piaget's symbolic-stage child, who could become someone else by jumping up and down like that other person.[17]

The types of experiencing of significant caregivers reconciled by character formation are evidenced in treatment, particularly in the transference, as well as in an individual's response to the rest of his social world. Thus, a patient such as Ms. B, who experienced her caregivers as having had her best interests at heart, may view the therapist and the boss as being for her best interests. A patient who experienced caregivers as suiting their own convenience will be more inclined to try to manipulate the therapist and others because he assumes they are out for their own good, not for his. A patient who experienced having to meet his caregivers' needs first may feel he must meet some need of the therapist in order to earn the therapist's help.

DIFFERENTIAL CONTEXTS

Similarly the therapeutic atmosphere created by the therapist will be experienced differently by patients with different character structures. The pure or scientific laboratory atmosphere or context may be quite effective with a patient such as Ms. B, who has an established identity and an internalized system of values. She is not dependent on the therapist for affirmation of identity or worth, and has come to therapy to do some work on herself. The pure or scientific laboratory atmosphere may scare off one who needs to feel connected in order to feel whole, such as Mr. A, or one who needs interaction with the therapist to know what the therapist is up to,

Closely allied to the style of social cognition and emanating from the early experience with significant caregivers is the primary investment or social goal of the character structure. An operational character, having experienced protective or overprotective and controlling caregivers, has developed a basic investment in function and control of function and in social roles and codes. In therapy he may be concerned whether he is functioning for himself, e.g. in producing material, or for the therapist, or may see the therapist as a protector (or rival). Seeing the therapist as a protector, Ms. B became confused as to who was in charge of choosing her career. The opaque mirror, abstinent context allows such confusion to surface. This hands-off posture conveys to such a patient that he is capable, entitled and responsible for functioning under his own auspices and allows for a classical transference interpretation. In Ms. B's case, a parental context would have supported her area of confusion and made a transference interpretation difficult.

An intuitive character who experienced caregivers as suiting their own convenience rather than seeing to his needs does not construct an internalized system of values. What he gets and what he has, his primary investment, determine his worth. He thus grasps at what looks good at the moment and is not only dependent on moment-to-moment supplies, but ofen finds himself in some kind of trouble because of his impulsiveness. He has difficulty judging what is good for him in the long run and has little ability to wait. Often the therapist must evaluate what is good for him and bad for him, must

set limits or teach him to do a better job of these functions for himself. The appropriate therapeutic atmosphere or context is a parenting one, in which the therapist may praise him for effective functioning and warn him about placing himself in jeopardy much as a good parent would do with a child. The intended message of this stance is that the therapist is on the patient's side.

A symbolic character who, because of his symbiotic experience with his caregivers, is confused as to what is essentially self and not self, what is part self and whole self, or part object and whole object, is invested in attaching and connecting. He may connect objects and events which are unrelated. He tends to think that if two things happen in conjunction with each other, one must have caused the other or be part of the other. Attachment to some person or role or activity may enable him to know who he is and where he is going. Attachment and avoidance of attachment is always an issue in therapy with a symbolic character. A psychotherapeutic context which allows for management of the degree of attachment permits the symbolic character to feel whole, a state in which he experiences less pain and is capable of better functioning. Mr. A interpreted the silence of his therapist to mean that there was a connection between them in which words from the therapist were not necessary in order for Mr. A to know that he was understood perfectly and cared for as he wished his parents had cared for him. The therapist was a benevolent presence to Mr. A. When the transference interpretation revealed that the therapist was not the perfect caregiver

which the patient longed for, the connection Mr. A had felt to the therapist was severed. Mr. A's pain around the intervention/disconnection was not dealt with. Had his disappointment been recognized, not analyzed, the connection might have been reestablished between him and a good enough, if not perfect, caregiver. Mr. A might have experienced the caregiver as a real person, for that moment, as well as a good enough caregiver.

The vignettes illustrate how a patient of one character structure perceives the abstinent atmosphere as a place to work while a patient of a different character structure perceives it as abandonment and assault.

CONCLUSION

Experienced therapists know that different patients experience similar contexts differently. Some recommend that a particular context, the abstinent one, be modified to accommodate patients other than those for whom it was designed. We recommend that the abstinent context be employed with the type of patients for whom it was intended and that other contexts, a parenting one or one which focuses on management of attachment, be created for other types of patients.

Our Piagetian-based model of character structure which dissects basic abiding character types is significant for psychotherapy insofar as it is useful to therapists in distinguishing different types of patients and in understanding why different types of patients experience a given psychotherapy approach differently, particularly the context aspect of the approach.

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